Clinical Practice Guidelines:
Neurological/Autonomic dysreflexia

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<tr>
<th>Date</th>
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<tr>
<td>Purpose</td>
<td>To ensure consistent management of patients with Autonomic dysreflexia.</td>
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<td>Scope</td>
<td>Applies to all QAS clinical staff.</td>
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<tr>
<td>Author</td>
<td>Clinical Quality &amp; Patient Safety Unit, QAS</td>
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**Autonomic dysreflexia (AD)** is a syndrome of massive imbalanced reflex sympathetic discharge occurring in patients with an existing, non-acute spinal cord injury above the level of T6. This condition can be caused by a number of different noxious stimuli, including:

- distended bladder due to blocked/kinked catheter
- urinary tract infection
- bowel irritation (e.g. constipation/faecal impaction)
- skin irritations (e.g. pressure sores, ingrown toenails, burns, sunburn)
- contracting uterus, fractures or any other event that would normally be deemed painful.

Removal of the noxious stimuli is the preferred management, however as this can often be difficult within the pre-hospital environment, symptomatic management to prevent cerebrovascular catastrophe and other complications is more often the primary goal.

Complications from AD occur due to sustained, severe peripheral hypertension and include cerebral haemorrhage, myocardial infarction and seizures.

### Clinical features

- Relative hypertension (BP for quadriplegics and high level paraplegics is typically low when lying and even lower when sitting ($\geq 90 - 100/60$ mmHg may be significant))
- Flushing of skin above the level of injury or paleness below level of injury
- Bradycardia
- Profuse sweating and piloerection above the level of injury
- Pounding headache (worsening symptoms as BP rises)
- Blurred vision, headache, CVA/TIA symptoms
- ACS

### Risk assessment

- Not applicable
Transport to hospital
Pre-notify as appropriate

Consider:
- GTN
- Morphine OR fentanyl

Note: Officers are only to perform procedures for which they have received specific training and authorisation by the QAS.